



# Department of Defense INSTRUCTION

NUMBER 6000.11

September 9, 1998

ASD(HA)

SUBJECT: Patient Movement

- References:
- (a) DoD Instruction 6000.11, "Medical Regulating," May 21, 1993  
(hereby canceled)
  - (b) [DoD Directive 6000.12](#), "Health Services Operations and Readiness,"  
April 29, 1996
  - (c) [DoD Directive 4500.9](#), "Transportation and Traffic Management,"  
January 26, 1989
  - (d) [DoD Directive 5158.4](#), "United States Transportation Command,"  
January 8, 1993
  - (e) through (m), see enclosure 1

## 1. REISSUANCE AND PURPOSE

This Instruction:

1.1. Reissues reference (a) and implements policy, assigns responsibilities, and prescribes procedures under reference (b) for standardizing medical regulating, and implementation of the DoD global patient movement mission.

1.2. Implements policy under references (c), (d), and (e), governing the management and use of Government aircraft.

1.3. Establishes procedures for movement of patients, medical attendants, related patient movement items, specialized medical care team members, and non-medical attendants on DoD-provided transportation. It explains eligibility for patient movement, policy for its use, responsibility for funding and reimbursement, applicability of tariff rates, and requirements for approval. This Instruction addresses both medical regulating (the identification of, and assignment to, medical treatment

facilities capable of providing required definitive, recuperative and/or restorative care to eligible beneficiaries) and aeromedical evacuation (AE) (the process of actually moving a patient through the U.S. Air Force (USAF) fixed wing AE system and focuses on process integration, wherever possible). It incorporates the AE provisions previously in Chapter 5, DoD 4515.13-R (reference (f)) with the procedures for broader DoD-provided patient movement and responsibilities for medical regulating.

1.4. Defines the conditions under which patient movement may be provided and identifies categories of patients eligible for patient movement. It further identifies conditions under which costs for patient movement services provided to DoD healthcare beneficiaries, other U.S. Government Agencies, private individuals or organizations, foreign countries, or foreign nationals are reimbursable to the Department of Defense. It prescribes procedures for central processing of reimbursements by the Global Patient Movement Requirements Center (GPMRC).

1.5. Transfers authority, direction, control and executive management of the Defense Medical Regulating Information System (DMRIS) and Automated Patient Evacuation System (APES) to the U.S. Transportation Command (USTRANSCOM). USTRANSCOM shall develop the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES), a single overall system that ties together patient accountability from the field, while in transit and at originating, destination, and enroute medical treatment facilities (MTFs). TRAC2ES shall provide intransit visibility and medical regulation of patients in both peacetime and contingencies.

## 2. APPLICABILITY AND SCOPE

This Instruction applies to:

2.1. The Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, and the Defense Agencies (hereafter referred to collectively as “the DoD Components”).

2.2. Under mutual agreement (reference (g)), the Office of the Secretary of Veterans Affairs (VA).

## 3. DEFINITIONS

Terms used in this Instruction are defined in enclosure 2.

#### 4. POLICY

It is DoD policy that:

4.1. The primary mission of the DoD patient movement system is to safely transport U.S. military casualties from the combat zone to fixed MTFs and/or field hospitals rearward in or out of the combat zone, as required. Other patients may be provided movement on a non-interference basis if the patient's medical condition, lack of local care, and patient movement costs warrant such movement.

4.2. Requests for medical regulating should be submitted to the appropriate Patient Movement Requirements Center (PMRC) after competent medical authority attests to the need to move the patient, and after the MTF commander determines that less expensive, acceptable quality care is not available locally. Patients will be regulated to the nearest appropriate MTF.

4.3. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) shall provide policy and oversight for medical regulating. As the DoD Executive Agent for patient care, provide program, budget, and financial development; and operational costs of all Automated Information Systems (AIS) for patient movement and AE transportation.

4.4. DoD transportation resources shall be organized and managed to ensure optimum responsiveness, efficiency, and economy to support the DoD mission. DoD-owned or -controlled transportation resources shall be used for official purposes only.

4.5. DoD transportation resources may be used to move non-DoD traffic only when the DoD mission shall not be impaired and movement of such traffic is of an emergency, lifesaving nature, specifically authorized by statute, in direct support of the DoD mission, or requested by the Head of an Agency of the Government under 31 U.S.C. 1535 and 1536 (reference (h)).

#### 5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

5.1.1. As the DoD Executive Agent for patient care, provide policy guidance, planning, and resources to support the Defense Health Program (DHP).

5.1.2. Provide guidance to Lead Agents and the Military Departments regarding the identification of Specialized Treatment Services (STS), readiness training cases, Graduate Medical Education (GME) and other programs; and the respective priority for use of these facilities as opposed to local care.

5.1.3. Program, budget and fund programs, or applicable portions of programs, supporting patient transportation, to include AISs such as the DMRIS and the TRAC2ES.

5.2. The Under Secretary of Defense for Acquisition and Technology shall be responsible for establishing policies and providing guidance to the DoD Components for efficient use of DoD and commercial transportation resources.

5.3. The Under Secretary of Defense (Comptroller) shall determine DoD patient movement-related reimbursable rates for collection by the GPMRC, and incorporate these rates with other DoD reimbursable rate guidance.

5.4. The Heads of the DoD Components and the Heads of the Uniformed Services shall:

5.4.1. Provide the USTRANSCOM Surgeon, GPMRC and Combatant Command Theater Patient Movement Requirement Centers (TPMRCs) the information required to support patient movement functions and responsibilities.

5.4.2. Ensure the affected components of their respective Components comply with, and provide assistance for, the standardized implementation of policy, procedures, and AIS for patient movement management.

5.4.3. Assign Uniformed Services' members and civilian personnel in sufficient numbers to ensure the ability to accomplish the patient movement mission, both in peacetime and during emergencies, contingencies, or war.

5.4.4. Provide medical administrative support to patients moved into VA and National Disaster Medical System (NDMS) facilities. Ensure Service personnel functions are aware of the location of patients to resolve any non-medical personnel issues.

5.4.5. Prepare implementing Component directives to ensure:

5.4.5.1. MTFs report into the applicable AIS all patients for whom local accountability (e.g., within 100 miles for ground transportation and all air transportation) are transferred from their facility to another facility.

5.4.5.2. Sending MTFs arrange and confirm billeting at the destination for outpatients and non-medical attendants before placing the personnel on patient transportation assets. Sending MTFs shall coordinate patient manifests with Aeromedical Staging Facilities that shall arrange and confirm billeting for patients who remain over night.

5.4.5.3. Receiving MTFs arrange necessary billeting for the inpatients if the receiving facility determines admission is not required after the patient arrives.

5.4.6. Ensure that USTRANSCOM and overseas command procedures for approving the return of patients who have completed treatment or have recovered are consistent with Service policies in situations where initial overseas clearance screenings require Military Department review and resolution (for Coast Guard personnel, the Commandant, United States Coast Guard (USCG)).

5.5. By mutual agreement, the Secretary of Veterans Affairs shall:

5.5.1. Provide medical capability information and assistance to the Director, GPMRC, as required.

5.5.2. Assign a full-time liaison officer to the GPMRC to provide assistance on the regulating and movement of patients to and from the VA MTFs.

5.5.3. Ensure the sharing of appropriate VA and DoD patient medical information, medical support infrastructure, medical care system(s) and policies, and AIS capabilities.

5.6. The Commander in Chief, United States Transportation Command, shall:

5.6.1. Establish global patient movement policy, and serve as the DoD single manager for patient movement, with the exception of intratheater patient movement.

5.6.1.1. In a peacetime environment, effective resource utilization and cost-effectiveness will be the deciding factors when determining a patient's hospital

destination and mode of transport. These lift-bed solutions must be consistent with patient care requirements.

5.6.2. Develop, publish, and issue, for the Department of Defense, standardized procedures for all AIS supporting patient movement.

5.6.3. Provide planning, programming, budgeting and fiscal input to enable the Undersecretary of Defense (Comptroller) (USD(C)) and ASD(HA) to provide proper funding for patient movement AISs and for Headquarters USAF to provide proper funding and flying hours for AE. USTRANSCOM, through its Service Executive Agent, will budget for those portions of patient movement AISs designated as primarily for transportation.

5.6.4. Serve as the functional manager to maintain and operate existing AIS patient movement systems. In cooperation with ASD(HA) and the Under Secretary of Defense for Personnel and Readiness, develop and maintain a global network system (TRAC2ES), with funding to be provided by ASD(HA), to assist in the command and control of patient movement and provide the ability to track in-transit Uniformed Services' patients and medical and/or non-medical assets used during medical transportation in both peace and contingency (military and civilian) operations. The system shall integrate the processes and AIS for medical regulating and include procedures to identify potentially available transportation assets, medical crews, medical crew augmentees, and equipment to aid in the movement of patients through the system without interruption. The centralized global system shall include the Continental United States (CONUS) and other theaters and shall provide decentralized execution for supported theater Combatant Commands for intratheater patient movement.

5.6.5. Establish and maintain the GPMRC, which shall:

5.6.5.1. In its global oversight role, recommend to USCINCTrans policies and procedures for intertheater lift and bed apportionment, lift-bed plan development, bed reservation, destination MTF designation, in-transit visibility for both patient and patient movement items, and patient tracking procedures.

5.6.5.2. Provide patient movement scheduling, validation, and requirements identification for intertheater operations.

5.6.5.3. Provide support to TPMRCs; designate portions of identified bed and lift resources to supported TPMRCs for intertheater lift-bed plan development;

and integrate and deconflict supported TPMRC plans and schedules.

5.6.5.4. Coordinate with supporting TPMRCs, transportation component commands, and other lift-bed allocators to identify available assets and communicate lift and bed requirements.

5.6.5.5. With the approval of the Combatant Commander of the destination theater, arrange for intertheater evacuations to be made directly from the supported combat theater to the MTF of the destination theater.

5.6.5.6. In accordance with Chapter 55 of 10 U.S.C., the "National Plan," and the MOU (references (i), (j) and (g)), GPMRC shall coordinate with the VA for treatment of patients in VA MTFs when required. The GPMRC shall also serve as the patient movement requirements center for the NDMS, in accordance with the NDMS partnership agreement and guidelines provided by the Director of Military Support (DOMS).

5.6.5.7. Serve as the only Third Party Collections and Revenue Reimbursable Collections manager for the worldwide patient movement system (to include CONUS, U.S. Pacific Command, U.S. European Command, U.S. Central Command, and U.S. Southern Command). Appropriate reimbursement for patient movement collected by the GPMRC will be credited to the appropriation supporting the maintenance and operation of the patient movement system.

5.6.5.8. Submit recommendations to the USD(C), with input from the Components providing patient movement support for enroute patient care and other related medical costs that could be used by the USD(C) when setting annual reimbursable rates for patient movement.

5.6.5.9. Function as the overall DoD global DMRIS and APES (TRAC2ES when implemented) network manager, operations, and training requirements identifier and capabilities provider (in conjunction with on-site and various remote site(s) contractor support) on behalf of USCINCTrans.

5.6.5.10. Approve exceptions to policy requests for intertheater and CONUS patient movement to support medical readiness requirements, continuity of care, regional contractor managed care support plans, OASD(HA), Chairman of the Joint Chiefs of Staff, U.S. Atlantic Command Integrated CONUS Medical Operations Plan execution direction, coordinated and approved Service, VA and U.S. Public Health Service guidance, and other requirements as appropriate. When clinical issues

are unclear, coordinate with the appropriate Uniformed Service clinical consultant for the specialty concerned.

5.6.5.11. Provide recommendations regarding the use of DoD, VA, and NDMS (or other civilian) facilities to optimize lift and bed resources.

5.6.5.12. Function as the CONUS TPMRC. Provide patient movement scheduling, validation, and requirements identification for CONUS. The GPMRC shall coordinate with supporting resource providers to identify available assets and communicate lift and bed requirements to providers.

5.6.6. Coordinate directly with Service Surgeon Generals and the VA for respective support and information required to establish a global patient movement network AIS.

5.6.7. Coordinate directly with Lead Agents to develop patient transportation networks to balance use of the DoD direct care and the civilian provider network consistent with ASD(HA)-defined resource utilization policies.

5.6.8. Recommend to the Department of Defense any delegation of responsibilities for execution of Department of State determinations to the command surgeon of the originating theater (and PMRC where appropriate) in cases where timeliness historically prevents advanced coordination.

5.6.9. Make recommendations, through the Chairman of the Joint Chiefs of Staff, to the ASD(HA) on policy issues relative to the capability, capacity, characteristics, design and other requirements for patient movement assets needed to execute the AE missions. USCINCTRANS shall submit proposed changes to medical regulating policies, procedures, and any applicable DoD Directives as needed to implement this Instruction.

5.6.10. Deploy joint patient movement teams in contingency operations to augment the PMRCs of the supported Combatant Commands, the GPMRC, the USTRANSCOM Mobility Control Center and Joint Mobility Assistance Teams; theater joint mobility control centers, or other activities requiring the ability to create or access patient movement requests, as requested.

5.6.11. Provide deliberate planning for all aspects of intertheater patient movement and participate in planning conferences to ensure professional standards for patient care and medical regulating are maintained and the most effective utilization of patient movement resources will be made during any exercise, natural disaster, or



contingency, to include identifying to the United States Atlantic Command (USACOM) time-phased potential CONUS distribution options.

5.7. The Commanders in Chief of OCONUS Combatant Commands shall:

5.7.1. Be responsible for intratheater patient movement in their area of responsibility.

5.7.2. Establish and maintain, as appropriate, TPMRCs. The TPMRC shall coordinate with supporting resource providers to identify available assets and communicate lift and bed requirements to providers for intratheater patient movement. The TPMRC shall have the authority to:

5.7.2.1. Ensure lift and bed requirements are communicated to supporting JPMRCs and MTFs, appropriate transportation agencies, and other Government Agencies within theater.

5.7.2.2. Determine policies and procedures for intratheater bed and lift management for Uniformed Services patients within their respective theaters.

5.7.2.2.1. Other eligible beneficiaries may be provided transport when their movement does not interfere with the timely or orderly accomplishment of the primary mission during peacetime or contingency operations.

5.7.2.2.2. In a peacetime environment, effective resource utilization and cost-effectiveness will be the deciding factors when determining a patient's hospital destination and mode of transport. These lift-bed solutions must be consistent with patient care requirements.

5.7.2.3. Designate portions of theater assigned lift and bed assets for use by Joint Patient Movement Requirements Centers (JPMRCs) to submit proposed JTF lift and bed plans for TPMRC approval.

5.7.2.4. Coordinate with the theater Components for the designation of portions of theater-assigned lift and bed assets for use by JPMRCs. The associated TPMRC will oversee and approve Joint Task Force (JTF)-coordinated JPMRC lift-bed plans.

5.7.2.5. Regulate Uniformed Services' patients from the supported combat theater directly into the theater MTFs of the other theater Unified Commands, or CONUS, consistent with USTRANSCOM-defined intertheater lift-bed procedures.

Such regulation shall be based on the medical capability and bed availability information provided for use by USCINTRANS.

5.7.2.6. Integrate and deconflict intratheater plans and schedules.

5.7.2.7. Generate and approve intratheater evacuation plans and schedules.

5.7.2.8. Develop proposed intertheater patient movement plans consistent with USTRANSCOM and GPMRC established procedures, and transportation priorities agreed to by the Chairman of the Joint Chiefs of Staff and/or supported CINC and USTRANSCOM for the respective contingency operation.

5.7.3. Participate in planning conferences to ensure professional standards for patient care and medical regulating are maintained and the most effective utilization of AE resources is made during any exercise, natural disaster, or contingency.

5.7.4. Recommend changes to procedures for patient movement AIS to USCINTRANS.

5.8. The Commander in Chief, U.S. Atlantic Command, shall:

5.8.1. Determine the supporting MTFs to be used for GPMRC bed apportionment and CONUS evacuation planning.

5.8.2. Serve as the point of contact on behalf of the Department of Defense for the VA-DoD National Plan.

## 6. PROCEDURES

6.1. GENERAL. Persons authorized medical care in DoD medical facilities are not necessarily entitled to DoD patient movement. Identified under “Criteria” are the conditions under which patient movement may be provided and categories of patients eligible for patient movement.

### 6.2. CRITERIA

6.2.1. Only patients specifically eligible for patient movement pursuant to DoD Directives, authorized by statute, or requested by the Head of a Government

Agency, under the Economy Act (reference (h)), may be provided transportation unless there is an emergency involving immediate threat to life, limb, or sight, suitable care is locally unavailable, and suitable commercial services (air taxi, charter air ambulance, and AE-configured commercial air, etc.) are neither available nor adequate. The Department of Defense is not permitted to compete with commercial activities in providing patient movement to other than authorized patients. Further, DoD transportation may not be used to provide financial relief for a patient or patient's family, or for convenience of the patient or patient's family.

6.2.2. The commander of a force engaged in combat or in a hostile fire situation may approve patient movement for patients and medical and nonmedical attendants in an aircraft not configured for AE, if the patients are facing a threat to life, limb, or sight. Any decision to use these transportation assets should consider the possible compromise to a patient's condition that may result from the use of non-AE assets.

6.2.3. Except for casualties returning to their place of residence or duty station from overseas deployments or contingencies, DoD-sponsored patient movement for inpatients and outpatients should be provided to the nearest appropriate MTF capable of providing the necessary care, unless the movement supports movement to designated STS, is consistent with regional managed care support contracts, supports GME or other approved programs, or supports an exception to policy as approved by the PMRC. Movement of returning patients from deployments or contingency operations will be in accordance with established operations plans or other contingency-specific implementing instructions or guidance. Patients originating outside CONUS who are not expected to return to duty and patients being separated from the Component by reason of disability should be moved to an MTF or VA Medical Center nearest the patient's selected place of residence. Patients who are expected to return overseas should be moved to the closest MTF to port of entry. Hospitalized patients who are away from their duty station may be returned to an MTF nearest their duty station.

6.2.4. Special air missions are not authorized for movement of terminally ill patients. Requests for movement of terminally ill patients before the next scheduled mission should be processed in accordance with DoD Directive 4500.43 (reference (e)).

6.2.5. DoD-sponsored patient movement is not authorized to transport a person for medical experimentation unless competent medical authority determines that such experimentation will save a patient's life, limb or sight.

6.2.6. A patient may not be moved CONUS to overseas, unless a patient is returning to an overseas duty location after completing treatment or as a recovered patient. Prior approval from the receiving overseas command and GPMRC is required before movement from CONUS to overseas.

6.2.7. When a military or USCG member or their dependents are moved via DoD-provided patient movement for permanent change of stations, reimbursement for costs shall be provided through the permanent change of station fund cite on the member's travel orders.

### 6.3. ELIGIBILITY FOR USE OF THE AE SYSTEM

6.3.1. DoD-Sponsored Patients. Uniformed Services patients, as defined in enclosure 2, may be provided transportation within or between theaters for inpatient and/or outpatient treatment or consultation that is unavailable locally from any DoD-approved healthcare facility, and for which movement is required. Specific authorizations for AE in-patient status are based on those specified for each category of DoD health beneficiary noted below.

6.3.2. Recovered Patients. DoD-sponsored patients and their dependents may be authorized patient transportation within and between theaters, and for return travel to their duty station when in recovered patient status.

#### 6.3.3. Nonmedical Attendants.

6.3.3.1. One able-bodied member of the immediate family of any patient provided DoD-sponsored transportation may also be provided DoD-sponsored transportation as a nonmedical attendant and authorized to accompany the patient when competent medical authority determines that a family member's presence is necessary to the patient's health and welfare. Additional family members may be allowed to accompany the patient, as an exception to policy, when necessary to the patient's health and welfare after approval by the Commander, or Director of the patient's MTF, and concurrence of the Director of the applicable PMRC. If a member of the immediate family is not available, another adult may accompany the patient in nonmedical attendant status on determination of need and written justification.

6.3.3.2. A nonmedical attendant whose status is lost due to the death, extended medical care requirements of the patient, or other circumstances may be provided space available DoD-sponsored transportation to the scheduled destination

nearest his or her originating location. However, in some cases, there may also be an entitlement for Government-funded transportation of surviving dependents to attend burial ceremonies of a deceased member. Consult the JFTR, Volume 1 (reference (k)) for definitive guidance. AE aircraft shall not be scheduled to move nonmedical attendants. Patient movement always takes priority over movement of nonmedical attendants.

6.3.3.3. Children are not eligible for nonmedical attendant status. The only exception are those breast-feeding infants traveling with their mothers and those children accompanying a family member with an immediate life-threatening condition who is traveling to undergo a potentially life-threatening surgical procedure (e.g. cardiothoracic or brain surgery). Such special cases will be reviewed and approved individually by the PMRC director.

6.3.4. Beneficiaries of Other U.S. Government Agencies and Other Government-Sponsored Patients. Patients sponsored by a U.S. Government Agency and authorized Government transportation according to the JTR, Volume 2 (reference (l)), may be provided patient movement. Reimbursement shall be made by the employee's Agency to USTRANSCOM at the non-DoD, U.S. Government tariff for all patient movement services provided.

6.3.5. Medical Attendants. The patient's medical condition will dictate the necessity of medical attendants. Medical attendant responsibilities are shared between all Uniformed Services but usually rest with the reporting facility.

6.3.6. Readiness Training Cases. Categories of patients, as approved by ASD(HA), such as burn cases, that provide a unique readiness value to both the patient movement system and the Military Health Services System.

6.3.7. Special Medical Support Personnel. Special medical support personnel missions are not AE missions. These individuals are authorized space required travel on channel missions. Movement requirements sooner than the next channel mission should be requested in accordance with DoD Directive 4500.43, reference (e).

6.3.8. Non-DoD Sponsored Patients. Non-DoD sponsored patients may be moved only if such movement is in direct support of the DoD mission, or when it does not interfere with the DoD mission and is an emergency, lifesaving situation, or is authorized by statute, or requested by the Head of an Agency of the Government pursuant to the Economy Act (reference (h)).

6.4. FINANCIAL CONSIDERATIONS. Except for casualties being returned from overseas deployments or contingencies and medical emergencies, and when appropriate medical care is available through civilian sources in the local community, MTF Commanders must determine if it is cost-effective to use the patient movement system. The cost comparison is between local civilian care and the “full” cost of care through the patient movement system. The full cost of the patient movement system includes MTF medical care cost as well as transportation, per diem, lodging, and lost duty time of patients and attendants. Enclosure 3 contains a flow chart that looks at the different steps used to determine the cost-effectiveness of using the patient movement system. A sample worksheet is included in enclosure 4 to provide a template for cost calculation.

6.4.1. Applicable patient movement charges shall conform to DoD reimbursement policies and third party billing procedures and guidance for collection in accordance with 32 CFR Part 220 (reference (m)). No reimbursement or billing point of contact will be required for the movement of patients to support-funded medical missions such as the Institute of Surgical Research, Fort Sam Houston, TX.

6.4.2. Persons eligible for patient transport may be provided movement using readiness baseline flying hours, schedules and priorities established by the GPMRC (TPMRC - overseas) with input from the DoD Regional Lead Agents and the tasked Component surgeons. Use of flying hours over the readiness baseline must be reimbursed. Business case analysis to determine whether or not a patient should be evacuated or retained locally should consider the cost and availability of PMRC-arranged transportation, the cost to retain the patient locally, and the potential for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE cost-shared transportation.

6.4.3 Commercial Transportation. For urgent or priority movements, use of commercial air ambulance and the purchase of commercially scheduled transportation by USTRANSCOM or its components is authorized if the cost benefit to the patient movement system can be clearly demonstrated.

6.4.4. Reimbursement

6.4.4.1. Reimbursement rates will be established each year by the DoD Comptroller for patient movement. Rates should consider both the costs of transportation and the cost of enroute medical care, and will cover both DoD and non-DoD beneficiary categories. Different rates for DoD beneficiaries can be

established when considering whether or not the supporting resources are provided from the DoD readiness baseline or from resources over and above the readiness baseline.

6.4.4.2. Nonmedical attendants shall be issued appropriate travel orders authorizing the same category of movement as the patient. Any reimbursements due the Government for patient movement that may apply to the patient shall also be applied to the nonmedical attendant. The orders should clearly provide all known reimbursable items, costs, corresponding accounting symbols, and complete billing address to facilitate processing by the responsible accounting and finance activity.

6.4.4.3. Reimbursements for Beneficiaries of Other U.S. Government Agencies and Other Government-Sponsored Patients shall be made by the employee's Agency to USTRANSCOM at the non-DoD, U.S. Government tariff for all patient movement services provided.

6.4.5. Readiness Training Cases. These patients can be provided patient movement without reimbursement by the sponsoring or accepting Component when non-Transportation Activity Group of the Air Force Working Capital Fund (Transportation Working Capital Fund (TWCF) reimbursable aircraft are used (e.g., DHP-funded C-9A program aircraft, Operational Support Airlift (OSA) aircraft, or C-21 for which reimbursement is not required). When a TWCF reimbursable source is used (e.g., C-141, C-5, C-17, etc.), Air Mobility Command for intertheater and CONUS and U.S. Air Forces Europe or U.S. Air Forces Pacific for overseas intratheater missions shall reimburse the TWCF. If the GPMRC, or supporting TPMRC, can arrange transportation using the readiness baseline-funded training hours, no reimbursement need be sought. Insurance companies and other third party payers will be billed for reimbursable charges if the case falls within the purview of a third party collection opportunity. Reimbursement for nonmedical attendants will be sought either directly from the patient's insurer, or the supported Component, unless otherwise directed by ASD(HA) and the USD(C).

6.4.6. Federal Emergency Management Agency (FEMA) Support. Requests passed from a FEMA agent, either at FEMA headquarters or at a field office, through the DOMS for patient movement will be collected for reimbursement in accordance with overall disaster assistance guidance provided by Chairman of the Joint Chiefs of Staff and/or DOMS and/or Forces Command or from FEMA on a case-by-case basis.

6.4.7. Reimbursement for U.S. civilian and foreign national patient and

attendant transport will be sought in accordance with established procedures for non-beneficiary support. The designation of a U.S. civilian or foreign national for movement by a Combatant Commander, Chairman of the Joint Chiefs of Staff, or other authority does not, in and of itself, obviate the need for payment.

6.5. PRIORITIES FOR PATIENT MOVEMENT. All medical considerations being equal, patients shall be prioritized for transportation as follows:

6.5.1. U.S. active duty Service member.

6.5.2. North Atlantic Treaty Organization (NATO) active duty Service member. NATO military personnel are eligible for patient movement while assigned or attached to a U.S. military installation. Patient movement is provided on a cost reimbursement basis.

6.5.3. Dependents of U.S. active duty Service members.

6.5.4. Other mission-essential Government Agency personnel. Includes only those civilians stationed in overseas areas. U.S. citizens who are employees of Uniformed Services; full-time, paid American Red Cross serving with the Department of Defense; professional scout leaders; United Service Organization professional staff serving with a Uniformed Service; and DoD Dependent School (DoDDS) teachers.

6.5.5. U.S. military retirees.

6.5.6. Dependents of U.S. military retirees.

6.5.7. Dependents of NATO active duty Service members. NATO dependents are eligible for patient movement if their NATO sponsor is assigned or attached to a U.S. military installation. Patient movement is provided on a cost reimbursement basis

6.5.8. Dependents of other Government Agency personnel. Includes only those civilians stationed in overseas areas who are U.S. citizens and are employees of Uniformed Services; full-time, paid American Red Cross serving with the Department of Defense; professional scout leaders; professional staff serving with a Uniformed Service; and DoDDS teachers.

6.5.9. Other Patients.

6.5.10. Nonmedical Attendants.



## 6.6. PROCEDURES FOR REQUESTING PATIENT MOVEMENT

6.6.1. Eligible Patients. Requests for patient movement are submitted by the responsible MTF to appropriate PMRC. In the CONUS, the GPMRC coordinates all subsequent aspects of the patient movement. In overseas theaters, the TPMRC coordinates all subsequent aspects of outside Continental United States (OCONUS)-intratheater patient movement. Mission preparation, coordination, and execution are then conducted under the direction of the tasked theater Service transportation component.

### 6.6.2. Ineligible Patients

6.6.2.1. Patient Movement Requests. Non-DoD use of DoD transportation may be provided in emergency, lifesaving situations or when the Head of a Government Executive Department or Agency, pursuant to the Economy Act (reference (h)), requests patient movement from PMRC, certifying it is in the best interests of the Government and that commercial transportation is not capable of meeting the requirement. That patient movement shall normally take place on a channel or regularly scheduled mission and must be clinically validated by the originating PMRC. A nonmedical attendant may accompany the patient when his or her presence is determined by competent medical authority to be essential to the patient's mental or physical well-being. The sponsoring authority's request to the appropriate PMRC must indicate the Agency or individuals responsible to reimburse USTRANSCOM and provide a specific name and address for direct billing of transportation and enroute medical charges at the applicable tariff rate.

### 6.6.2.2. Request for Urgent Patient Movement in Overseas Areas

6.6.2.2.1. U.S. Civilians. On receipt of a request for lifesaving movement in overseas commands, the theater surgeon concerned is authorized to approve movement of U.S. citizens (on a reimbursable basis) when it is determined that an emergency involving immediate threat to life, limb, or sight exists, adequate care is locally unavailable or unsuitable, and suitable commercial transportation is neither available nor adequate.

6.6.2.2.2. Foreign Nationals. The U.S. joint forces commander responsible for the area in which the emergency arises has approval authority in coordination with the Department of State (DoS) and the destination theater Combatant Commander for patient movement to the most expedient capable MTF if the patient's

injury or illness is directly related to U.S. Government operations within the area. Otherwise, requests for movement of foreign nationals must be forwarded to the responsible PMRC through the local diplomatic post and DoS, Washington, DC for a determination of whether the movement is in the national interest and a confirmation of the DoS or other U.S. Government Agency's authority and requirements for placing a request under the Economy Act (reference (h)). When the critical nature of the patient's illness or injury prevents submission of a request, the theater PMRC may approve movement based on a DoS determination of U.S. interests and commitment to reimburse the Department of Defense for patient movement costs. A message shall be sent from the PMRC to the GPMRC with an information copy to Headquarters, U.S. Air Force, Managed Care Division, confirming the mission and indicating reimbursement source (other Government Agency, the Uniformed Service, private insurance, etc.).

6.6.2.2.3. Requests for movement of patients under subparagraphs 6.6.2.2.1. and 6.6.2.2.2. will be considered on a case-by-case basis and after coordination with receiving host-nation immigration officials. Requests for patient movement of foreign nationals that are being treated in U.S. MTFs must be submitted through the theater Combatant Commander.

#### 6.7. CONUS DISASTER PATIENT MOVEMENT SUPPORT

6.7.1. Requests. Requests for patient movement during disasters in CONUS shall be initiated by the FEMA. Requests shall typically flow from FEMA to the DOMS in the Office of the Army Deputy Chief of Staff, Operations and Plans, to the Secretary of Defense, to the Chairman of the Joint Chiefs of Staff for execution through the USTRANSCOM, with a simultaneous information copy to USACOM as the lead operational authority for the Department of Defense for Military Support to Civil Authorities.

6.7.2. Reimbursement. FEMA support missions are reimbursable to the USTRANSCOM at the non-DoD U.S. Government rate.

#### 6.8. CRITERIA FOR APPROVAL OF PATIENT MOVEMENT

6.8.1. Routine. Missions are scheduled, in coordination with the appropriate PMRC, and executed by the responsible AE squadron. During contingencies coordination is through the appropriate PMRC to the theater Service transportation component.

6.8.1.1. Intertheater channel AE missions are jointly scheduled by the GPMRC and the USTRANSCOM Mobility Control Center, and origin or destination PMRC. CINC, USTRANSCOM, must annually approve routine channel missions.

6.8.1.2. Intratheater channel AE C-9A missions are scheduled by the appropriate PMRC and are reviewed annually and approved by the Theater Air Component Surgeon. The USTRANSCOM Surgeon in the CONUS and the Theater Air Component Surgeons must annually validate AE channel missions in their areas of responsibility based on recommendations from the GPMRC and respective PMRCs. Schedules will be based on the most efficient use of flying hours.

6.8.2. Priority or Urgent. The following criterion shall be strictly adhered to in approving patient movement requirements: The patient is located where medical capabilities for adequate diagnosis and treatment, under generally acceptable medical standards, are not available unless DoD-provided patient movement is utilized. DoD-provided patient movement shall be provided only to the nearest medical facility that can provide necessary medical care and for which transportation is the most cost-effective.

6.8.3. Approval Authority. After obtaining patient movement request information, the responsible PMRC shall approve or disapprove and coordinate patient movement.

7. EFFECTIVE DATE

This Instruction is effective immediately.

  
Assistant Secretary of Defense for  
Health Affairs

Enclosures - 4

- E1. References, continued
- E2. Definitions
- E3. AE Use Flowchart
- E4. Methodology to Evaluate Cost-Effective Use of Patient Movement

E1. ENCLOSURE 1

REFERENCES, continued

- (e) [DoD Directive 4500.43](#), "Operational Support Airlift (OSA)," October 28, 1996
- (f) DoD 4515.13-R, "Air Transportation Eligibility," November 1994, authorized by DoD Directive 4500.9, January 26, 1989
- (g) Memorandum of Understanding between the Department of Defense and the Veterans Administration, "Referral of Active Duty Patients to Veterans Administration Medical Facilities," June 10, 1986
- (h) Sections 1535 and 1536 of title 31, United States Code, "The Economy Act"
- (i) Chapter 55 of title 10, United States Code
- (j) Veterans Administration-Department of Defense Contingency Planning (National Plan), May 1983
- (k) Joint Federal Travel Regulations, Volume 1, "Uniformed Services Members," current edition
- (l) Joint Travel Regulations, Volume 2, "Department of Defense Civilian Personnel," current edition
- (m) Title 32, Code of Federal Regulations, Part 220

## E2. ENCLOSURE 2

### DEFINITIONS

#### E2.1. TERMS

Following are the definitions:

E2.1.1. Accessibility. Access to DoD-approved healthcare in the treating MTF's catchment area.

E2.1.2. Aeromedical Evacuation (AE). The movement of patients by aircraft.

E2.1.3. Aeromedical Evacuation Coordination Center (AECC). A coordination center within the Joint Air Operations Center, which monitors all activities related to AE operations execution. It manages the medical aspects of the AE mission and serves as the net control station for AE communications. It coordinates medical requirements with airlift capability, assigns medical missions to the appropriate AE elements, and monitors patient movement activities.

E2.1.4. AE Patient. A patient classified by competent medical authority as a candidate for patient movement.

#### E2.1.5. AE Patient Priorities

E2.1.5.1. Routine AE Patient. A patient who requires movement but can wait for a regularly scheduled channel AE mission, a scheduled military airlift channel mission, or commercially-procured airlift service.

E2.1.5.2. Priority AE Patient. A patient who requires movement within 24 hours to save life, limb, or eyesight (typically sooner than the next scheduled channel AE mission or sooner than can be accommodated using scheduled channel mission, or commercially-procured airlift service).

E2.1.5.3. Urgent AE Patient. A patient who requires movement as soon as possible to save life, limb, or eyesight. Immediate action shall be taken to obtain AE or other suitable transportation to meet patient requirements. Terminally ill or psychiatric patients are not considered urgent patients.

E2.1.6. Automated Information System (AIS). Methodologies as well as

automated data processing hardware and software designed to store, track, and manage incoming and outgoing information, and/or aid in decision support.

E2.1.7. Channel AE Mission. A regularly scheduled AE mission that is flown over an established route.

E2.1.8. Competent Medical Authority. A military, civilian, or contract physician of the Department of Defense, the USCG, the United States Public Health Service (USPHS), or VA. This individual has the responsibility to provide or arrange the necessary medical care of a patient and provide medical validation that patient movement is required.

E2.1.9. CONUS Disaster Patient Movement Support. AE movement of patients, medicine, or medical equipment to alleviate the effects of a life-threatening disaster in the CONUS. This applies to military casualties and civilian casualties when requested on a reimbursable basis to the Department of Defense by the U.S. Government Agency responsible for managing evacuation operations.

E2.1.10. Global Patient Movement Requirements Center (GPMRC). The primary role of the GPMRC is to coordinate with supporting resource providers (e.g., DoD MTFs, DoD Regional Lead Agents, USACOM, MCC, TACC, JOSAC, VA, USPHS) to identify assets that can be designated for use by the supported PMRCs, collaborate and integrate PMRC scheduling, and communicate lift and bed requirements to providers. The GPMRC merges the medical regulating and patient movement scheduling functions. The GPMRC also functions as the CONUS TPMRC.

E2.1.11. Intertheater Patient Movement. Moving patients between, into, and out of the different theaters of the geographic Combatant Commands and into the CONUS or another supporting theater.

E2.1.12. In-Transit Visibility. The ability to locate and track, by name and/or unique identifier, individual patients being medically evacuated from point of origin to final destination, while in the patient movement system.

E2.1.13. Intratheater Patient Movement. Moving patients within the theater of a Combatant Command or in the CONUS.

E2.1.14. Joint Patient Movement Requirements Center (JPMRC). The JPMRC provides TPMRC-type domain, AIS support, and operations, for a JTF operating within a Unified Command area of responsibility. The TPMRC maintains overall responsibility for theater patient movement operations, but the JPMRC is responsible

for patient movement operations within its area scope of responsibility, and coordinates with the TPMRC for intratheater patient movement and the GPMRC (when direct liaison is authorized by the TPMRC) for intertheater patient movement.

E2.1.15. Lead Agent. The office responsible for administering a TRICARE Health Service Region. The Lead Agent may also be the commander of a major medical facility located in the area. The office functions as the focal point for health services and collaborates with the other military treatment facility commanders within the region to develop an integrated plan for the delivery of healthcare for beneficiaries.

E2.1.16. Medical Attendants. Medical personnel, in addition to medical aircrew, assigned to patient movement missions in support of a specific patient's medical requirements.

E2.1.17. Medical Regulating. A process that selects destination medical MTFs for Uniformed Services patients being medically evacuated.

E2.1.18. Nonmedical Attendant. A person authorized to accompany a patient on a patient movement mission, based on the following:

E2.1.18.1. Recommendation by the patient's attending physician that the person's presence is essential to the welfare of the patient;

E2.1.18.2. Approval by the commander or director of the patient's MTF; and

E2.1.18.3. Concurrence of the applicable PMRC.

E2.1.19. Patient Movement. The act or process of moving a sick, injured, wounded, or other person to obtain medical and/or dental care or treatment. Decisions made in this process involve coordination between the sending MTF, the gaining MTF, and the GPMRC/TPMRC.

E2.1.20. Patient Movement Requirements Center (PMRC). Term used to represent any Theater, Joint or the Global Patient Movement Requirements Center function.

E2.1.21. Recovered Patient. A person discharged or returning from medical treatment who is authorized to travel on DoD-owned or DoD-controlled aircraft.

E2.1.22. Secretarial Designee. A person not normally a DoD healthcare beneficiary, who is designated for care in a Military MTF by the Secretary of Defense



or the Secretary of the Military Department concerned. AE shall not be provided unless specifically authorized by the Secretary and the designation document states that the sponsoring Secretary shall reimburse for patient movement costs.

E2.1.23. Special Medical Support Personnel. Medical and other support personnel who are required at a patient on-load point to assist with the enroute medical care during the movement of a patient (e.g., Critical Care Air Transport Team). This definition also includes organ transplant teams that may traveling to harvest an organ or transport an organ.

E2.1.24. Special Air Mission. A non-scheduled patient movement mission, executed to move a patient, patient's medicine, body organs intended for transplant, or medical equipment (may be accomplished using regularly scheduled "channel" or Special Airlift Mission aircraft, or commercially-procured services).

E2.1.25. Specialized Treatment Services. Designated Military MTFs for highly specialized care; e.g., the Army's Institute of Surgical Research (Burn Center) at Fort Sam Houston, TX.

E2.1.26. Tanker Airlift Control Center (TACC). Responsible for operational control and mission oversight of all intertheater patient movement missions and intratheater patient movement missions utilizing strategic airlift assets.

E2.1.27. Theater Patient Movement Requirements Center (TPMRC). The TPMRC is responsible for theater-wide patient movement (e.g., medical regulating and AE scheduling), and coordinates with theater MTFs to allocate the proper treatment assets required to support its role. The primary role of the TPMRC is to devise theater plans and schedules and then monitor their execution in concert with the GPMRC. The TPMRC is responsible to the Combatant Commander through the Combatant Command Surgeon. The TPMRC is also responsible for all aspect of intratheater patient movement management. A TPMRC provides command and control for patient movement management operations in its theater of operations, as directed by its Combatant Commander's operational policy, and in coordination with USTRANSCOM, acting as a supporting Combatant Command, responsible for intertheater and CONUS patient movement.

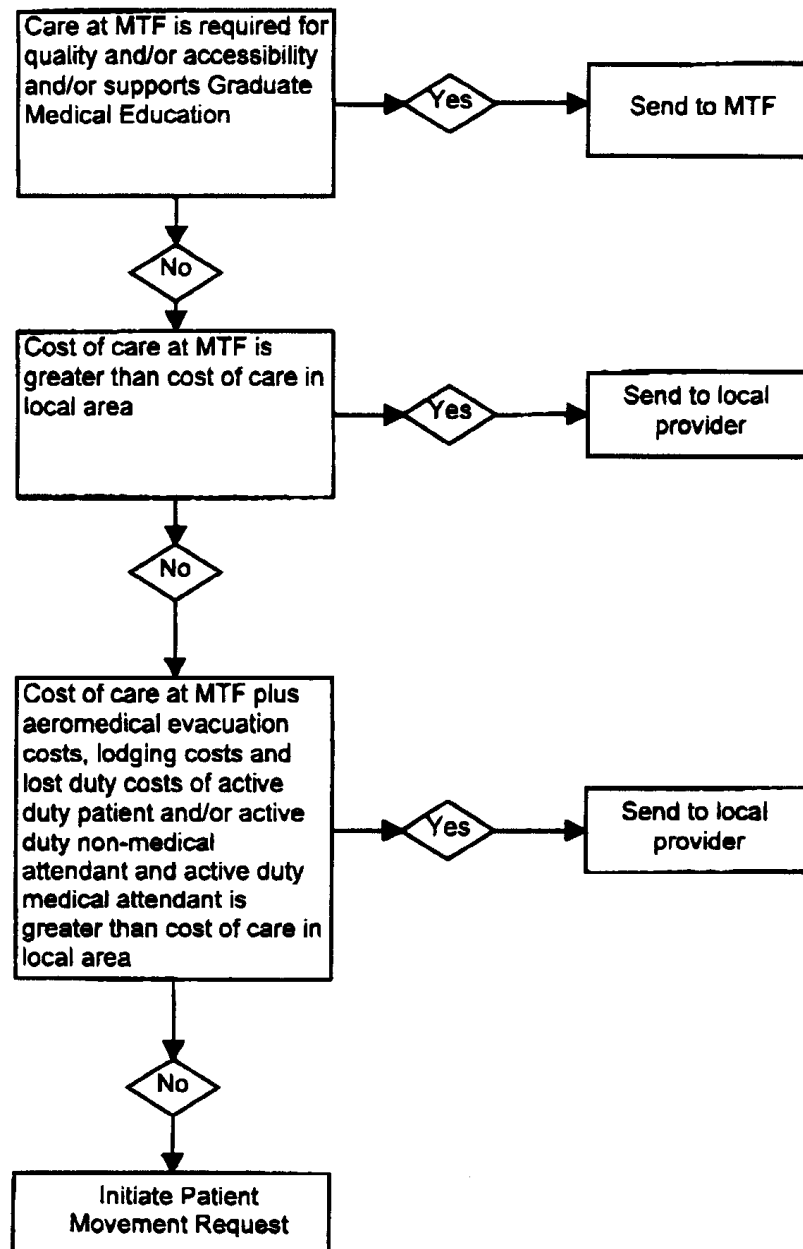
E2.1.28. Uniformed Services Patients are patients in the following categories:

E2.1.28.1. Members of a Uniformed Service performing active duty, active duty for training, or inactive duty for training.

E2.1.28.2. Members of a Uniformed Service who are receiving retired pay.

E2.1.28.3. A family member of a member of a Uniformed Service on active duty for more than 30 days, a family member of a member who dies while performing active duty for more than 30 days, a family member of a member receiving retired pay, or a family member of a deceased retired member who is authorized medical care under Chapter 55 of 10 U.S.C. (reference (i)).

E2.1.28.4. Other categories of eligible beneficiaries who are in military medical channels, as authorized by the Secretaries of the Military Departments concerned or the Secretary of Defense.

E3. ENCLOSURE 3FLOWCHART TO EVALUATE USE OF AEROMEDICAL EVACUATION

E4. ENCLOSURE 4  
METHODOLOGY TO EVALUATE COST-EFFECTIVE USE OF PATIENT  
MOVEMENT

E4.1. Is care available at originating MTF?

If, yes, provide care at MTF.

If, no, go to question E4.2.

E4.2. Is care at destination MTF required as a graduate medical education case?

If, yes, use patient movement.

If, no, go to question E4.3.

E4.3. Is care available from local DoD-approved civilian provider?

If, yes, go to question E4.4.

If, no, use patient movement.

E4.4. Does local civilian care meet DoD quality and access standards?

If, yes, go to question E4.5.

If, no, use patient movement.

E4.5. Is cost of care from local provider less than at destination MTF?

If, yes, use local civilian provider.

If, no, use patient movement.

Outpatient Cost Calculator			
Outpatient Visit Type	Local Provider Cost Estimate	Destination MTF Cost	
ICD9-CM Code	CHAMPUS Table	DoD Rate Table (Based on workcenter Costs)	
			Add the following costs for patient movement:
		1 \$1,632	2 Transportation
		+	Per Diem
		+	Lodging
		+	Lost Duty Costs
		+	Other Costs
3 Total Cost	\$XXXX	\$YYYY	
1 This is a sample number -- use transportation costs provided by USD(C).			
2 PMRCs will establish an AE schedule using available readiness baseline flying hours. When moving patients on these patient movement channel missions, the cost of transportation can be considered as "0" because the transportation has already been funded.			
3 If local provider costs are greater than total destination MTF Cost, use patient movement. If not, provide care locally.			

Inpatient Cost Calculator			
Inpatient DRG Code	Local Provider Cost Estimate	Destination MTF Cost	
	CHAMPUS Allowable + Professional Service Cost	DRG wt X ASA rate	
			Add the following costs for patient movement:
		1 \$1,632	2 Transportation
		+	Per Diem
		+	Lodging
		+	Lost Duty Costs
		+	Other Costs
3 Total Cost	\$XXXX	\$YYYY	
1 This is a sample number -- use transportation costs provided by USD(C).			
2 PMRCs will establish an AE schedule using available readiness baseline flying hours. When moving patients on these patient movement channel missions, the cost of transportation can be considered as "0" because the transportation has already been funded.			
3 Build lookup tables in the spreadsheet so that when the DRG number is entered, both the CHAMPUS and MTF cost based on ASA and DRG weight is calculated. A per diem table can also be built to automatically calculate that cost. If enough information is available for calculating the lost duty time, another table can be made to accommodate that calculation. If local civilian provider costs are less than full MTF costs, provide care locally. If care is more cost-effective at destination MTF, use aeromedical evacuation.			